REFERENCE TITLE: state health plan

State of Arizona
House of Representatives
Forty-seventh Legislature
Second Regular Session
2006

HB 2752

Introduced by
Representatives Lopes, Bradley, Downing, Gallardo, Sinema: Alvarez, Kirkpatrick, Prezelski

AN ACT

AMENDING TITLE 36, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 31; AMENDING TITLE 41, CHAPTER 27, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 41-3016.01; RELATING TO THE STATE HEALTH PLAN.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, Arizona Revised Statutes, is amended by adding chapter 31, to read:

CHAPTER 31

STATE HEALTH PLAN

ARTICLE 1. GENERAL PROVISIONS

36-3101. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "BENEFICIARY" MEANS A PERSON WHO IS ELIGIBLE FOR HEALTH CARE AND BENEFITS PURSUANT TO THE HEALTH PLAN.

2. "BUDGET" MEANS THE TOTAL OF ALL CATEGORIES OF DOLLAR AMOUNTS OF EXPENDITURES FOR A STATED PERIOD AUTHORIZED FOR AN ENTITY OR A PROGRAM.

3. "CAPITAL BUDGET" MEANS THAT PORTION OF A BUDGET THAT ESTABLISHES EXPENDITURES FOR EITHER:

(a) ACQUISITION OR ADDITION OF SUBSTANTIAL IMPROVEMENT TO REAL PROPERTY.

(b) ACQUISITION OF TANGIBLE PERSONAL PROPERTY.

4. "CASE MANAGEMENT" MEANS A COMPREHENSIVE PROGRAM DESIGNED TO MEET AN INDIVIDUAL'S NEED FOR CARE BY COORDINATING AND LINKING THE COMPONENTS OF HEALTH CARE.

5. "COMMISSION" MEANS THE HEALTH CARE COMMISSION.

6. "CONSUMER PRICE INDEX FOR MEDICAL CARE PRICES" MEANS THAT INDEX AS PUBLISHED BY THE BUREAU OF LABOR STATISTICS OF THE FEDERAL DEPARTMENT OF LABOR.

7. "FINANCIAL INTEREST" MEANS AN OWNERSHIP INTEREST OF ANY AMOUNT, DIRECT OR INDIRECT.

8. "GROUP PRACTICE" MEANS AN ASSOCIATION OF HEALTH CARE PRACTITIONERS THAT PROVIDES ONE OR MORE SPECIALIZED HEALTH CARE SERVICES OR A TRIBAL OR URBAN INDIAN COALITION IN PARTNERSHIP OR UNDER CONTRACT WITH THE FEDERAL INDIAN HEALTH SERVICE THAT IS AUTHORIZED UNDER FEDERAL LAW TO PROVIDE HEALTH CARE TO NATIVE AMERICAN POPULATIONS IN THIS STATE.

9. "HEALTH CARE" MEANS HEALTH CARE PRACTITIONER SERVICES AND HEALTH FACILITY SERVICES.

10. "HEALTH CARE PRACTITIONER" MEANS:

(a) A PERSON LICENSED OR CERTIFIED TO PROVIDE HEALTH CARE PURSUANT TO TITLE 32.

(b) A PERSON LICENSED OR CERTIFIED BY A NATIONALLY RECOGNIZED PROFESSIONAL ORGANIZATION AND DESIGNATED AS A HEALTH CARE PRACTITIONER BY THE COMMISSION.

(c) A PERSON IN A GROUP PRACTICE OF LICENSED PRACTITIONERS.

(d) A TRANSPORTATION SERVICE.

11. "HEALTH FACILITY" MEANS:

(a) A SCHOOL-BASED CLINIC.

(b) AN INDIAN HEALTH SERVICE FACILITY.

(c) A TRIBALLY OPERATED HEALTH CARE FACILITY.

(d) A LICENSED GENERAL HOSPITAL.
(e) A SPECIAL HOSPITAL.
(f) AN OUTPATIENT FACILITY.
(g) A PSYCHIATRIC HOSPITAL.
(h) A LABORATORY.
(i) A SKILLED NURSING FACILITY.
(j) A NURSING FACILITY.

12. "HEALTH PLAN" MEANS THE PROGRAM THAT IS ESTABLISHED AND ADMINISTERED BY THE COMMISSION PURSUANT TO THIS CHAPTER.

13. "MAJOR CAPITAL EXPENDITURE" MEANS CONSTRUCTION OR RENOVATION OF FACILITIES OR THE ACQUISITION OF DIAGNOSTIC, TREATMENT OR TRANSPORTATION EQUIPMENT BY A HEALTH CARE PRACTITIONER OR A HEALTH FACILITY THAT COSTS MORE THAN AN AMOUNT RECOMMENDED AND ESTABLISHED BY THE COMMISSION.

14. "OPERATING BUDGET" MEANS THE BUDGET OF A HEALTH FACILITY EXCLUSIVE OF THE FACILITY'S CAPITAL BUDGET.

15. "PERSON" MEANS AN INDIVIDUAL OR ANY OTHER LEGAL ENTITY.

16. "PRIMARY CARE PRACTITIONER" MEANS AN ALLOPATHIC PHYSICIAN, OSTEOPATHIC PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR OTHER HEALTH CARE PRACTITIONER CERTIFIED BY THE COMMISSION.

17. "PRACTITIONER BUDGET" MEANS THE AUTHORIZED EXPENDITURES PURSUANT TO PAYMENT MECHANISMS ESTABLISHED BY THE COMMISSION TO PAY FOR HEALTH CARE FURNISHED BY HEALTH CARE PRACTITIONERS PARTICIPATING IN THE HEALTH PLAN.

18. "TRANSPORTATION SERVICE" MEANS A PERSON PROVIDING THE SERVICES OF AN AMBULANCE, HELICOPTER OR OTHER CONVEYANCE THAT IS EQUIPPED WITH HEALTH CARE SUPPLIES AND EQUIPMENT AND THAT IS USED TO TRANSPORT PATIENTS TO OTHER HEALTH CARE PRACTITIONERS OR HEALTH FACILITIES.

36-3102. Health care commission; membership

A. THE HEALTH CARE COMMISSION IS ESTABLISHED CONSISTING OF THE FOLLOWING MEMBERS:

1. FIVE PUBLIC MEMBERS WHO ARE APPOINTED BY THE GOVERNOR.

2. TWO PUBLIC MEMBERS WHO ARE APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

3. TWO PUBLIC MEMBERS WHO ARE APPOINTED BY THE PRESIDENT OF THE SENATE.

B. COMMISSION MEMBERS SERVE STAGGERED FIVE YEAR TERMS THAT BEGIN AND END ON THE THIRD MONDAY IN JANUARY. COMMISSION MEMBERS SHALL NOT SERVE FOR MORE THAN TWO SUCCESSIVE FIVE YEAR TERMS OR FOR MORE THAN TEN CONSECUTIVE YEARS.

C. IF REQUESTED BY THE COMMISSION, THE APPOINTING AUTHORITY MAY REMOVE A COMMISSION MEMBER FOR MISCONDUCT, INCOMPETENCE OR NEGLECT OF DUTY.

D. COMMISSION MEMBERS ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2 TO COVER NECESSARY EXPENSES FOR ATTENDING EACH COMMISSION MEETING OR FOR REPRESENTING THE COMMISSION IN AN OFFICIAL COMMISSION APPROVED ACTIVITY.

E. COMMISSION MEMBERS MUST BE RESIDENTS OF THIS STATE AND MAY NOT HAVE ANY FINANCIAL INTEREST IN ANY HEALTH CARE PROFESSION.

F. A COMMISSION MEMBER WHO ACTS WITHIN THE SCOPE OF COMMISSION DUTIES, WITHOUT MALICE AND IN THE REASONABLE BELIEF THAT THE PERSON'S ACTION IS WARRANTED BY LAW IS NOT SUBJECT TO CIVIL LIABILITY.

36-3103. Executive director

A. THE COMMISSION SHALL HIRE AN EXECUTIVE DIRECTOR AS AN EMPLOYEE OF THE COMMISSION. THE EXECUTIVE DIRECTOR IS RESPONSIBLE FOR THE PERFORMANCE OF THE REGULAR ADMINISTRATIVE FUNCTIONS OF THE COMMISSION AND THE ADMINISTRATION OF THIS CHAPTER.

B. THE COMMISSION MAY HIRE OTHER EMPLOYEES NECESSARY TO CARRY OUT THIS CHAPTER AND MAY CONTRACT WITH OTHER STATE AGENCIES TO CARRY OUT THIS CHAPTER.

36-3104. Duties of the commission

THE COMMISSION SHALL:

1. ADOPT A FIVE YEAR PLAN FOR THE INITIAL IMPLEMENTATION OF THE HEALTH PLAN AS PRESCRIBED BY THIS CHAPTER, UPDATE THAT PLAN AND ADOPT OTHER LONG-RANGE AND SHORT-RANGE PLANS TO PROVIDE CONTINUITY AND DEVELOPMENT OF THE STATE'S HEALTH CARE SYSTEM.

2. DESIGN THE HEALTH PLAN TO FULFILL THE PURPOSES OF AND CONFORM TO THE REQUIREMENTS OF THE HEALTH PLAN AS PRESCRIBED BY THIS CHAPTER FOR IMPLEMENTATION BEGINNING JANUARY 1, 2009.

3. PROVIDE A PROGRAM TO EDUCATE THE PUBLIC, HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES ABOUT THE HEALTH PLAN AND THE PERSONS ELIGIBLE TO RECEIVE ITS BENEFITS.

4. STUDY AND ADOPT AS PROVISIONS OF THE HEALTH PLAN PRESCRIBED BY THIS CHAPTER COST-EFFECTIVE METHODS OF PROVIDING QUALITY HEALTH CARE TO ALL BENEFICIARIES, GIVING HIGH PRIORITY TO INCREASED RELIANCE ON:

(a) PREVENTIVE AND PRIMARY CARE THAT INCLUDES IMMUNIZATION AND SCREENING EXAMINATIONS.

(b) PROVIDING HEALTH CARE IN RURAL OR UNDERSERVED AREAS OF THIS STATE.

(c) IN-HOME AND COMMUNITY-BASED ALTERNATIVES TO INSTITUTIONAL HEALTH CARE.

(d) CASE MANAGEMENT SERVICES IF APPROPRIATE.

5. ESTABLISH COMPENSATION METHODS FOR HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES AND ADOPT STANDARDS AND PROCEDURES FOR NEGOTIATING AND ENTERING INTO CONTRACTS WITH PARTICIPATING HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES.

6. ANNUALLY, AND FOR THOSE PROJECTED FUTURE PERIODS THE COMMISSION BELIEVES APPROPRIATE, ESTABLISH HEALTH PLAN BUDGETS.

7. ESTABLISH CAPITAL BUDGETS FOR HEALTH FACILITIES, LIMITED TO CAPITAL EXPENDITURES SUBJECT TO THE REQUIREMENTS OF THIS CHAPTER, AND INCLUDE IN THOSE BUDGETS:

(a) STANDARDS AND PROCEDURES FOR DETERMINING THE BUDGETS.

(b) A REQUIREMENT FOR PRIOR APPROVAL BY THE COMMISSION FOR MAJOR CAPITAL EXPENDITURES BY A HEALTH FACILITY.

8. NEGOTIATE AND ENTER INTO HEALTH CARE RECIPROCITY AGREEMENTS WITH OTHER STATES AND COUNTRIES AND NEGOTIATE AND ENTER INTO HEALTH CARE AGREEMENTS WITH OUT-OF-STATE HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES.

9. DEVELOP CLAIMS AND PAYMENT PROCEDURES FOR HEALTH CARE PRACTITIONERS, HEALTH FACILITIES AND CLAIMS ADMINISTRATORS AND INCLUDE PROVISIONS TO ENSURE TIMELY PAYMENTS AND PROVIDE FOR PAYMENT OF INTEREST IF REIMBURSABLE CLAIMS ARE NOT PAID WITHIN A REASONABLE TIME.

10. IN CONJUNCTION WITH OTHER STATE AGENCIES SIMILARLY CHARGED, ESTABLISH A SYSTEM TO COLLECT AND ANALYZE STANDARD HEALTH DATA AND OTHER DATA NECESSARY TO IMPROVE THE QUALITY, EFFICIENCY AND EFFECTIVENESS OF HEALTH CARE AND TO CONTROL COSTS OF HEALTH CARE IN THIS STATE. THE SYSTEM SHALL INCLUDE DATA ON THE FOLLOWING:

(a) MORTALITY, INCLUDING ACCIDENTAL CAUSES OF DEATH.

(b) NATALITY.

(c) MORBIDITY.

(d) HEALTH BEHAVIOR.

(e) PHYSICAL AND PSYCHOLOGICAL IMPAIRMENT AND DISABILITY.

(f) HEALTH CARE SYSTEM COSTS AND HEALTH CARE AVAILABILITY, UTILIZATION AND REVENUES.

(g) ENVIRONMENTAL FACTORS.

(h) AVAILABILITY, ADEQUACY AND TRAINING OF HEALTH CARE PERSONNEL.

(i) DEMOGRAPHIC FACTORS.

(j) SOCIAL AND ECONOMIC CONDITIONS AFFECTING HEALTH.

(k) HEALTH OUTCOMES.

(l) OTHER FACTORS AS DETERMINED BY THE COMMISSION.

11. STANDARDIZE DATA COLLECTION AND SPECIFIC METHODS OF MEASUREMENT ACROSS DATABASES AND USE SCIENTIFIC SAMPLING OR COMPLETE ENUMERATION FOR REPORTING HEALTH INFORMATION.

12. ESTABLISH A HEALTH CARE DELIVERY SYSTEM THAT IS EFFICIENT TO ADMINISTER AND THAT ELIMINATES UNNECESSARY ADMINISTRATIVE COSTS.

13. ADOPT RULES NECESSARY TO IMPLEMENT AND MONITOR A PREFERRED DRUG LIST, BULK PURCHASING OR OTHER MECHANISM TO PROVIDE PRESCRIPTION DRUGS AND A PRICING PROCEDURE FOR NONPRESCRIPTION DRUGS, DURABLE MEDICAL EQUIPMENT AND SUPPLIES, EYEGLASSES, HEARING AIDS AND OXYGEN.

14. ESTABLISH A PHARMACY AND THERAPEUTICS COMMITTEE TO:

(a) CONDUCT CONCURRENT, PROSPECTIVE AND RETROSPECTIVE DRUG UTILIZATION REVIEW.

(b) CONDUCT PHARMACOLOGIC RESEARCH AND ANALYSIS OF CLINICAL SAFETY, EFFICACY AND EFFECTIVENESS OF DRUGS.

(c) CONSULT WITH SPECIALISTS IN APPROPRIATE FIELDS OF MEDICINE FOR THERAPEUTIC CLASSES OF DRUGS.

(d) RECOMMEND THERAPEUTIC CLASSES OF DRUGS, INCLUDING SPECIFIC DRUGS WITHIN EACH CLASS TO BE INCLUDED IN THE PREFERRED DRUG LIST.

(e) IDENTIFY APPROPRIATE EXCLUSIONS FROM THE PREFERRED DRUG LIST.

(f) CONDUCT PERIODIC CLINICAL REVIEWS OF PREFERRED, NONPREFERRED AND NEW DRUGS.

15. STUDY AND EVALUATE THE ADEQUACY AND QUALITY OF HEALTH CARE FURNISHED PURSUANT TO THIS CHAPTER, THE COST OF EACH TYPE OF SERVICE AND THE EFFECTIVENESS OF COST CONTAINMENT MEASURES IN THE HEALTH PLAN.

16. STUDY AND MONITOR THE MIGRATION OF PERSONS TO THIS STATE TO DETERMINE IF PERSONS WITH COSTLY HEALTH CARE NEEDS ARE MOVING TO THIS STATE TO RECEIVE HEALTH CARE, AND IF MIGRATION APPEARS TO THREATEN THE FINANCIAL STABILITY OF THE HEALTH PLAN, RECOMMEND TO THE LEGISLATURE CHANGES IN ELIGIBILITY REQUIREMENTS, PREMIUMS OR OTHER CHANGES THAT MAY BE NECESSARY TO MAINTAIN THE FINANCIAL INTEGRITY OF THE HEALTH PLAN.

17. ESTABLISH AND APPROVE CHANGES IN COVERAGE BENEFITS AND BENEFIT STANDARDS IN THE HEALTH PLAN.

18. CONDUCT NECESSARY INVESTIGATIONS AND INQUIRIES.

19. ADOPT RULES NECESSARY TO IMPLEMENT, ADMINISTER AND MONITOR THE OPERATION OF THE HEALTH PLAN.

20. ADOPT RULES TO ESTABLISH A PROCUREMENT PROCESS FOR SERVICES AND PROPERTY.

21. MEET AS NEEDED, BUT NOT LESS THAN ONCE EVERY MONTH.

22. SUBMIT AN ANNUAL REPORT TO THE GOVERNOR, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE AND PROVIDE A COPY OF THIS REPORT TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE REPORT SHALL INCLUDE THE FOLLOWING:

(a) A SUMMARY OF INFORMATION ABOUT HEALTH CARE NEEDS, HEALTH OUTCOMES, HEALTH CARE SERVICES, HEALTH CARE EXPENDITURES, REVENUES RECEIVED AND PROJECTED REVENUES AND OTHER RELEVANT ISSUES RELATING TO THE HEALTH PLAN, THE INITIAL FIVE YEAR PLAN AND FUTURE UPDATES OF THAT PLAN AND OTHER LONG-RANGE AND SHORT-RANGE PLANS.

(b) RECOMMENDATIONS ON METHODS TO CONTROL HEALTH CARE COSTS AND IMPROVE ACCESS TO AND THE QUALITY OF HEALTH CARE FOR STATE RESIDENTS, AS WELL AS RECOMMENDATIONS FOR LEGISLATIVE ACTION.

36-3105. Commission authority

THE COMMISSION HAS THE AUTHORITY NECESSARY TO CARRY OUT THE POWERS AND DUTIES PURSUANT TO THIS CHAPTER. THE COMMISSION RETAINS RESPONSIBILITY FOR ITS DUTIES BUT MAY DELEGATE AUTHORITY TO THE EXECUTIVE DIRECTOR EXCEPT, THAT THE AUTHORITY TO TAKE THE FOLLOWING ACTIONS IS EXPRESSLY RESERVED TO THE COMMISSION:

1. APPROVE THE COMMISSION'S BUDGET AND PLAN OF OPERATION.

2. APPROVE THE HEALTH PLAN AND MAKE CHANGES IN THE HEALTH PLAN, BUT ONLY AFTER LEGISLATIVE APPROVAL OF THOSE CHANGES PURSUANT TO SECTION 36-3121.

3. ADOPT RULES AND CONDUCT BOTH RULE MAKING AND ADJUDICATORY HEARINGS IN PERSON OR BY USE OF AN ADMINISTRATIVE LAW JUDGE.

4. ISSUE SUBPOENAS TO PERSONS TO APPEAR AND TESTIFY BEFORE THE COMMISSION AND TO PRODUCE DOCUMENTS AND OTHER INFORMATION RELEVANT TO THE

COMMISSION'S INQUIRY AND ENFORCE THIS SUBPOENA POWER THROUGH AN ACTION IN THE SUPERIOR COURT.

5. MAKE REPORTS AND RECOMMENDATIONS TO THE LEGISLATURE.

6. SUBJECT TO THE REQUIREMENTS OF SECTION 36-3112, APPLY FOR PROGRAM WAIVERS FROM ANY GOVERNMENTAL ENTITY IF THE COMMISSION DETERMINES THAT THE WAIVERS ARE NECESSARY TO ENSURE THE PARTICIPATION BY THE GREATEST POSSIBLE NUMBER OF BENEFICIARIES.

7. APPLY FOR AND ACCEPT GRANTS, LOANS AND DONATIONS.

8. ACQUIRE OR LEASE REAL PROPERTY AND MAKE IMPROVEMENTS ON IT AND ACQUIRE BY LEASE OR BY PURCHASE TANGIBLE AND INTANGIBLE PERSONAL PROPERTY.

9. DISPOSE OF AND TRANSFER PERSONAL PROPERTY, BUT ONLY AT PUBLIC SALE AFTER ADEQUATE NOTICE.

10. APPOINT AND PRESCRIBE THE DUTIES OF EMPLOYEES, FIX THEIR COMPENSATION, PAY THEIR EXPENSES AND PROVIDE AN EMPLOYEE BENEFIT PROGRAM.

11. ESTABLISH AND MAINTAIN BANKING RELATIONSHIPS, INCLUDING ESTABLISHMENT OF CHECKING AND SAVINGS ACCOUNTS.

12. ENTER INTO AGREEMENTS WITH EMPLOYERS TO PROVIDE HEALTH CARE SERVICES FOR THE EMPLOYERS' EMPLOYEES OR RETIREES. THIS CHAPTER DOES NOT REDUCE OR ELIMINATE BENEFITS TO WHICH THE EMPLOYEE OR RETIREE IS ENTITLED.

36-3106. Advisory boards

THE COMMISSION MAY ESTABLISH ADVISORY BOARDS TO ASSIST IT IN PERFORMING ITS DUTIES. ADVISORY BOARDS SHALL ASSIST THE COMMISSION IN MATTERS REQUIRING THE EXPERTISE AND KNOWLEDGE OF THE ADVISORY BOARDS' MEMBERS.

36-3107. Health care delivery regions

THE COMMISSION SHALL ESTABLISH HEALTH CARE DELIVERY REGIONS IN THIS STATE BASED ON GEOGRAPHY AND HEALTH CARE RESOURCES. THE REGIONS MAY HAVE DIFFERENTIAL FEE SCHEDULES, BUDGETS, CAPITAL EXPENDITURE ALLOCATIONS OR OTHER FEATURES TO ENCOURAGE THE PROVISION OF HEALTH CARE IN RURAL AND OTHER UNDERSERVED AREAS OR TO OTHERWISE TAILOR THE DELIVERY OF HEALTH CARE TO FIT THE NEEDS OF A REGION OR A PART OF A REGION.

36-3108. Health plan

A. AFTER NOTICE AND PUBLIC HEARING, INCLUDING TAKING PUBLIC COMMENT AND THE REPORTS OF THE REGIONAL COUNCILS, THE COMMISSION, IN CONJUNCTION WITH OTHER APPROPRIATE STATE AGENCIES, SHALL ADOPT A FIVE YEAR HEALTH PLAN AND REVIEW IT AT REGULAR INTERVALS FOR POSSIBLE REVISION.

B. THE HEALTH PLAN SHALL BE DESIGNED TO PROVIDE COMPREHENSIVE, NECESSARY AND APPROPRIATE HEALTH CARE BENEFITS, INCLUDING PREVENTIVE HEALTH CARE AND PRIMARY, SECONDARY AND TERTIARY HEALTH CARE FOR ACUTE AND CHRONIC CONDITIONS. THE HEALTH PLAN MAY PROVIDE FOR CERTAIN HEALTH CARE SERVICES TO BE PHASED IN AS THE HEALTH PLAN BUDGET ALLOWS.

C. PURSUANT TO THE PHASE-IN REQUIREMENTS OF SUBSECTION B OF THIS SECTION, THE COMMISSION SHALL PROVIDE FOR COVERAGE OF THE FOLLOWING HEALTH CARE SERVICES:

1. PREVENTIVE HEALTH SERVICES.

2. HEALTH CARE PRACTITIONER SERVICES.

3. HEALTH FACILITY INPATIENT AND OUTPATIENT SERVICES.
4. LABORATORY TESTS AND RADIOLOGY PROCEDURES.
5. HOSPICE CARE.
6. IN-HOME, COMMUNITY-BASED AND INSTITUTIONAL LONG-TERM CARE SERVICES.
7. PRESCRIPTION DRUGS.
8. INPATIENT AND OUTPATIENT MENTAL AND BEHAVIORAL HEALTH SERVICES.
9. DRUG AND OTHER SUBSTANCE ABUSE SERVICES.
10. PREVENTIVE AND PROPHYLACTIC DENTAL SERVICES, INCLUDING AN ANNUAL DENTAL EXAMINATION AND CLEANING.
11. VISION APPLIANCES, INCLUDING MEDICALLY NECESSARY CONTACT LENSES.
12. MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND SELECTED ASSISTIVE DEVICES, INCLUDING HEARING AND SPEECH ASSISTIVE DEVICES.
13. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES OR TREATMENTS AS SPECIFIED BY THE COMMISSION.

D. COVERED HEALTH CARE DOES NOT INCLUDE:

1. SURGERY FOR COSMETIC PURPOSES OTHER THAN FOR RECONSTRUCTIVE PURPOSES.
2. MEDICAL EXAMINATIONS AND MEDICAL REPORTS PREPARED FOR PURCHASING OR RENEWING LIFE INSURANCE OR PARTICIPATING AS A PLAINTIFF OR DEFENDANT IN A CIVIL ACTION FOR THE RECOVERY OR SETTLEMENT OF DAMAGES.
3. ORTHODONTIC SERVICES AND COSMETIC DENTAL SERVICES EXCEPT THOSE COSMETIC DENTAL SERVICES NECESSARY FOR RECONSTRUCTIVE PURPOSES.

E. THE HEALTH PLAN SHALL SPECIFY THE HEALTH CARE TO BE COVERED AND THE AMOUNT, SCOPE AND DURATION OF BENEFITS.

F. THE HEALTH PLAN SHALL CONTAIN PROVISIONS TO CONTROL HEALTH CARE COSTS SO THAT BENEFICIARIES RECEIVE COMPREHENSIVE, HIGH-QUALITY HEALTH CARE CONSISTENT WITH AVAILABLE REVENUE AND BUDGET CONSTRAINTS.

G. THE HEALTH PLAN SHALL PHASE IN BENEFICIARIES AS THEIR PARTICIPATION BECOMES POSSIBLE THROUGH CONTRACTS, WAIVERS OR FEDERAL LEGISLATION. THE HEALTH PLAN MAY PROVIDE FOR CERTAIN PREVENTIVE HEALTH CARE TO BE OFFERED TO RESIDENTS OF THIS STATE REGARDLESS OF A PERSON'S ELIGIBILITY TO PARTICIPATE AS A BENEFICIARY.

H. THE FIVE YEAR PLAN AS WELL AS OTHER LONG-RANGE AND SHORT-RANGE PLANS ADOPTED BY THE COMMISSION SHALL BE REVIEWED BY THE REGIONAL COUNCILS AND THE COMMISSION ANNUALLY AND REVISED AS NECESSARY. REVISIONS SHALL BE ADOPTED BY THE COMMISSION PURSUANT TO SECTION 36-3104. IN PROJECTING SERVICES UNDER THE HEALTH PLAN, THE COMMISSION SHALL TAKE ALL REASONABLE STEPS TO ENSURE THAT LONG-TERM CARE AND DENTAL CARE ARE PROVIDED AT THE EARLIEST PRACTICABLE TIMES CONSISTENT WITH BUDGET CONSTRAINTS.

36-3109. Long-term care

A. NOT LATER THAN ONE YEAR AFTER THE EFFECTIVE DATE OF THIS CHAPTER, THE COMMISSION SHALL APPOINT AN ADVISORY LONG-TERM CARE COMMITTEE MADE UP OF REPRESENTATIVES OF HEALTH CARE CONSUMERS, PRACTITIONERS AND ADMINISTRATORS TO DEVELOP A PLAN FOR INTEGRATING LONG-TERM CARE INTO THE HEALTH PLAN. THE COMMITTEE SHALL REPORT ITS PLAN TO THE COMMISSION NOT LATER THAN ONE YEAR

AFTER ITS APPOINTMENT. COMMITTEE MEMBERS ARE ELIGIBLE TO RECEIVE REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

B. THE LONG-TERM CARE COMPONENT OF THE HEALTH PLAN SHALL PROVIDE FOR CASE MANAGEMENT AND NONINSTITUTIONAL SERVICES IF APPROPRIATE.

C. SUBJECT TO THE REQUIREMENTS OF SECTIONS 36-3131 AND 36-3132, THIS SECTION DOES NOT AFFECT LONG-TERM CARE SERVICES PAID THROUGH PRIVATE INSURANCE OR STATE OR FEDERAL PROGRAMS.

D. THIS SECTION DOES NOT PREVENT THE COMMISSION FROM INCLUDING LONG-TERM CARE SERVICES FROM THE INCEPTION OF THE HEALTH PLAN.

36-3110. Mental and behavioral health services

A. NOT LATER THAN ONE YEAR AFTER APPOINTMENT OF THE EXECUTIVE DIRECTOR, THE COMMISSION SHALL APPOINT AN ADVISORY MENTAL AND BEHAVIORAL HEALTH SERVICES COMMITTEE MADE UP OF REPRESENTATIVES OF MENTAL AND BEHAVIORAL HEALTH CARE CONSUMERS, PRACTITIONERS AND ADMINISTRATORS TO DEVELOP A PLAN FOR COORDINATING MENTAL AND BEHAVIORAL HEALTH SERVICES WITHIN THE HEALTH PLAN. THE COMMITTEE SHALL REPORT ITS PLAN TO THE COMMISSION NOT LATER THAN ONE YEAR AFTER ITS APPOINTMENT. COMMITTEE MEMBERS ARE ELIGIBLE TO RECEIVE REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

B. THE MENTAL AND BEHAVIORAL HEALTH SERVICES COMPONENT OF THE HEALTH PLAN SHALL PROVIDE FOR CASE MANAGEMENT AND NONINSTITUTIONAL SERVICES IF APPROPRIATE.

C. THE HEALTH PLAN SHALL NOT IMPOSE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ON THE PROVISION OF MENTAL AND BEHAVIORAL HEALTH BENEFITS IF IDENTICAL LIMITATIONS OR REQUIREMENTS ARE NOT IMPOSED ON COVERAGE OF BENEFITS FOR OTHER CONDITIONS.

D. SUBJECT TO THE REQUIREMENTS OF SECTIONS 36-3131 AND 36-3132, THIS SECTION DOES NOT LIMIT MENTAL AND BEHAVIORAL HEALTH SERVICES PAID THROUGH PRIVATE INSURANCE OR STATE OR FEDERAL PROGRAMS.

36-3111. Medicaid coverage; agreements

THE COMMISSION MAY ENTER INTO APPROPRIATE AGREEMENTS WITH OTHER STATE AGENCIES FOR THE PURPOSE OF FURTHERING THE GOALS OF THIS CHAPTER. THESE AGREEMENTS MAY PROVIDE FOR CERTAIN SERVICES PROVIDED PURSUANT TO TITLE XIX AND TITLE XXI OF THE SOCIAL SECURITY ACT TO BE ADMINISTERED BY THE COMMISSION TO IMPLEMENT THE HEALTH PLAN.

36-3112. Health plan coverage; conditions of eligibility for beneficiaries; exclusions

A. AN INDIVIDUAL IS ELIGIBLE AS A BENEFICIARY OF THE HEALTH PLAN IF THE INDIVIDUAL HAS BEEN PHYSICALLY PRESENT IN THIS STATE FOR AT LEAST ONE YEAR BEFORE THE DATE OF APPLICATION FOR ENROLLMENT IN THE HEALTH PLAN AND IF THE INDIVIDUAL HAS A CURRENT INTENTION TO REMAIN IN THIS STATE AND NOT TO RESIDE ELSEWHERE. A DEPENDENT OF AN ELIGIBLE INDIVIDUAL IS INCLUDED AS A BENEFICIARY.

B. INDIVIDUALS COVERED UNDER THE FOLLOWING GOVERNMENTAL PROGRAMS SHALL NOT BE BROUGHT INTO COVERAGE:

1. FEDERAL RETIREE HEALTH PLAN BENEFICIARIES.
2. ACTIVE DUTY AND RETIRED MILITARY PERSONNEL.
3. INDIVIDUALS COVERED BY THE FEDERAL ACTIVE AND RETIRED MILITARY HEALTH PROGRAMS.

C. FEDERAL INDIAN HEALTH SERVICE OR TRIBALLY OPERATED HEALTH CARE PROGRAM BENEFICIARIES SHALL NOT BE BROUGHT INTO COVERAGE EXCEPT THROUGH AGREEMENTS WITH:

1. INDIAN COMMUNITIES.
2. CONSORTIA OF INDIAN COMMUNITIES.
3. A FEDERAL INDIAN HEALTH SERVICE AGENCY SUBJECT TO THE APPROVAL OF THE INDIAN COMMUNITIES LOCATED IN THAT AGENCY.

D. IF AN INDIVIDUAL IS INELIGIBLE DUE TO THE RESIDENCE REQUIREMENT, THE INDIVIDUAL MAY BECOME ELIGIBLE BY PAYING THE PREMIUM REQUIRED BY THE HEALTH PLAN FOR COVERAGE FOR THE PERIOD OF TIME UP TO THE DATE THE INDIVIDUAL FULFILLS THAT REQUIREMENT IF THE INDIVIDUAL IS AN EMPLOYEE WHO PHYSICALLY RESIDES AND INTENDS TO RESIDE IN THIS STATE.

E. AN EMPLOYER THAT PROVIDES HEALTH CARE BENEFITS FOR ITS EMPLOYEES AFTER RETIREMENT, INCLUDING COVERAGE FOR PAYMENT OF HEALTH CARE SUPPLEMENTARY COVERAGE IF THE RETIREE IS ELIGIBLE FOR MEDICARE, MAY AGREE TO PARTICIPATE IN THE HEALTH PLAN IF THERE IS NO LOSS OF BENEFITS UNDER THE RETIREE HEALTH BENEFIT COVERAGE. AN EMPLOYER THAT PARTICIPATES IN THE HEALTH PLAN SHALL CONTRIBUTE TO THE HEALTH PLAN FOR THE BENEFIT OF THE RETIREE, AND THE AGREEMENT SHALL ENSURE THAT THE HEALTH BENEFIT COVERAGE FOR THE RETIREE IS RESTORED IF THE RETIREE BECOMES INELIGIBLE FOR HEALTH PLAN COVERAGE.

F. THE COMMISSION SHALL PRESCRIBE BY RULE CONDITIONS UNDER WHICH OTHER PERSONS IN THIS STATE MAY BE ELIGIBLE FOR COVERAGE PURSUANT TO THE HEALTH PLAN.

36-3113. Health plan coverage of nonresident students

A. EXCEPT AS PROVIDED IN SUBSECTION B, AN EDUCATIONAL INSTITUTION SHALL PURCHASE COVERAGE UNDER THE HEALTH PLAN FOR ITS NONRESIDENT STUDENTS THROUGH FEES ASSESSED TO THOSE STUDENTS. THE GOVERNING BODY OF AN EDUCATIONAL INSTITUTION SHALL SET THE FEES AT THE AMOUNT DETERMINED BY THE COMMISSION.

B. A NONRESIDENT STUDENT AT AN EDUCATIONAL INSTITUTION MAY SATISFY THE REQUIREMENT FOR HEALTH CARE COVERAGE BY PROOF OF COVERAGE UNDER A POLICY OR PLAN IN ANOTHER STATE THAT IS ACCEPTABLE TO THE COMMISSION. THE STUDENT SHALL NOT BE ASSESSED A FEE IN THAT CASE.

C. THE COMMISSION SHALL ADOPT RULES TO DETERMINE PROOF OF AN INDIVIDUAL'S ELIGIBILITY FOR THE HEALTH PLAN OR A STUDENT'S PROOF OF NONRESIDENT HEALTH CARE COVERAGE.

36-3114. Removing ineligible persons

THE COMMISSION SHALL ADOPT RULES TO PROVIDE PROCEDURES FOR REMOVING PERSONS WHO ARE NO LONGER ELIGIBLE FOR COVERAGE.

36-3115. Eligibility card; use; misuse of care; violation; classification

A. A BENEFICIARY SHALL RECEIVE A CARD AS PROOF OF ELIGIBILITY. THE CARD SHALL BE ELECTRONICALLY READABLE AND SHALL CONTAIN A PICTURE OR ELECTRONIC IMAGE, INFORMATION THAT IDENTIFIES THE BENEFICIARY FOR TREATMENT, BILLING AND PAYMENT AND OTHER INFORMATION THE COMMISSION DEEMS NECESSARY. THE USE OF A BENEFICIARY'S SOCIAL SECURITY NUMBER AS AN IDENTIFICATION NUMBER IS NOT PERMITTED.

B. THE ELIGIBILITY CARD IS NOT TRANSFERABLE. A BENEFICIARY WHO LENDS THE BENEFICIARY'S CARD TO ANOTHER AND AN INDIVIDUAL WHO USES ANOTHER'S CARD ARE JOINTLY AND SEVERALLY LIABLE TO THE COMMISSION FOR THE FULL COST OF THE HEALTH CARE PROVIDED TO THE USER. THE LIABILITY SHALL BE PAID IN FULL WITHIN ONE YEAR AFTER FINAL DETERMINATION OF LIABILITY. LIABILITIES ESTABLISHED PURSUANT TO THIS SECTION SHALL BE COLLECTED IN A MANNER SIMILAR TO THAT USED FOR COLLECTION OF DELINQUENT TAXES.

C. A BENEFICIARY WHO LENDS THE BENEFICIARY'S CARD TO ANOTHER OR AN INDIVIDUAL WHO USES ANOTHER'S CARD AFTER BEING DETERMINED LIABLE PURSUANT TO SUBSECTION B OF A PREVIOUS MISUSE IS GUILTY OF A CLASS 2 MISDEMEANOR. A BENEFICIARY WHO IS CONVICTED OF A THIRD OR SUBSEQUENT CONVICTION IS GUILTY OF A CLASS 6 FELONY.

36-3116. Primary care practitioner; right to choose; access to services

A. EXCEPT AS OTHERWISE PRESCRIBED BY LAW, A BENEFICIARY MAY CHOOSE A PRIMARY CARE PRACTITIONER.

B. THE PRIMARY CARE PRACTITIONER IS RESPONSIBLE FOR PROVIDING HEALTH CARE PRACTITIONER SERVICES TO THE PATIENT EXCEPT FOR:

1. SERVICES IN MEDICAL EMERGENCIES.

2. SERVICES FOR WHICH A PRIMARY CARE PRACTITIONER DETERMINES THAT SPECIALIST SERVICES ARE REQUIRED, IN WHICH CASE THE PRIMARY CARE PRACTITIONER MUST ADVISE THE PATIENT OF THE NEED FOR AND THE TYPE OF SPECIALIST SERVICES.

C. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, HEALTH CARE PRACTITIONER SPECIALISTS SHALL BE PAID PURSUANT TO THE HEALTH PLAN ONLY IF THE PATIENT HAS BEEN REFERRED BY A PRIMARY CARE PRACTITIONER. THIS SUBSECTION DOES NOT PREVENT A BENEFICIARY FROM OBTAINING THE SERVICES OF A HEALTH CARE PRACTITIONER SPECIALIST AND PAYING THE SPECIALIST FOR SERVICES PROVIDED.

D. THE COMMISSION BY RULE SHALL SPECIFY WHEN AND UNDER WHAT CIRCUMSTANCES A BENEFICIARY MAY SELF-REFER, INCLUDING SELF-REFERRAL TO A CHIROPRACTIC PHYSICIAN, A DOCTOR OF ORIENTAL MEDICINE, MENTAL AND BEHAVIORAL HEALTH SERVICE PRACTITIONERS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT PRIMARY CARE PRACTITIONERS.

E. THE COMMISSION BY RULE SHALL SPECIFY THE CONDITIONS UNDER WHICH A BENEFICIARY MAY SELECT A SPECIALIST AS A PRIMARY CARE PRACTITIONER.

36-3117. Discrimination prohibited

A HEALTH CARE PRACTITIONER OR HEALTH FACILITY SHALL NOT DISCRIMINATE AGAINST OR REFUSE TO FURNISH HEALTH CARE TO A BENEFICIARY ON THE BASIS OF AGE, RACE, COLOR, INCOME LEVEL, NATIONAL ORIGIN, RELIGION, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY, DISABLING CONDITION OR PAYMENT STATUS. THIS SECTION DOES NOT REQUIRE A HEALTH CARE PRACTITIONER OR HEALTH FACILITY TO PROVIDE SERVICES TO A BENEFICIARY IF THE PRACTITIONER OR FACILITY IS NOT QUALIFIED TO PROVIDE THE NEEDED SERVICES OR DOES NOT OFFER THEM TO THE GENERAL PUBLIC.

36-3118. Claims review

A. THE COMMISSION SHALL ADOPT RULES TO PROVIDE A COMPREHENSIVE CLAIMS REVIEW PROGRAM. THE PROCEDURES AND STANDARDS USED IN THE PROGRAM SHALL BE DISCLOSED IN WRITING TO APPLICANTS, BENEFICIARIES, HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES AT THE TIME OF APPLICATION TO OR PARTICIPATION IN THE HEALTH PLAN.

B. THE DECISION TO APPROVE OR DENY A CLAIM BASED ON A TECHNICALITY SHALL BE MADE IN A TIMELY MANNER AND SHALL NOT EXCEED TIME LIMITS ESTABLISHED BY RULE OF THE COMMISSION. A FINAL DECISION TO DENY PAYMENT FOR SERVICES BASED ON MEDICAL NECESSITY OR UTILIZATION SHALL BE BASED ON A RECOMMENDATION MADE BY A HEALTH CARE PROFESSIONAL HAVING APPROPRIATE AND ADEQUATE QUALIFICATIONS TO MAKE THE RECOMMENDATION. A DENIAL OF A CLAIM FOR PAYMENT OF A MEDICAL SPECIALTY SERVICE BASED ON MEDICAL NECESSITY OR UTILIZATION SHALL BE MADE ONLY AFTER A WRITTEN RECOMMENDATION FOR DENIAL IS MADE BY A MEMBER OF THAT MEDICAL SPECIALTY WITH CREDENTIALS EQUIVALENT TO THOSE OF THE PRACTITIONER.

C. THE FACT OF AND THE SPECIFIC REASONS FOR A DENIAL OF A HEALTH CARE CLAIM SHALL BE COMMUNICATED PROMPTLY IN WRITING TO BOTH THE PRACTITIONER AND THE BENEFICIARY INVOLVED.

36-3119. Quality of care; health care practitioner and health facilities; practice standards

A. THE COMMISSION SHALL ADOPT RULES TO ESTABLISH AND IMPLEMENT A QUALITY IMPROVEMENT PROGRAM THAT MONITORS THE QUALITY AND APPROPRIATENESS OF HEALTH CARE PROVIDED BY THE HEALTH PLAN, INCLUDING EVIDENCE-BASED BEST PRACTICES, OUTCOME MEASUREMENTS, CONSUMER EDUCATION AND PATIENT SAFETY. THE COMMISSION SHALL SET STANDARDS AND REVIEW BENEFITS TO ENSURE THAT EFFECTIVE, COST-EFFICIENT, HIGH QUALITY AND APPROPRIATE HEALTH CARE IS PROVIDED UNDER THE HEALTH PLAN.

B. THE COMMISSION SHALL REVIEW AND ADOPT PROFESSIONAL PRACTICE GUIDELINES DEVELOPED BY STATE AND NATIONAL HEALTH CARE AND SPECIALTY ORGANIZATIONS, FEDERAL AGENCIES FOR HEALTH CARE POLICY AND RESEARCH AND OTHER ORGANIZATIONS AS IT DEEMS NECESSARY TO PROMOTE THE QUALITY AND COST-EFFECTIVENESS OF HEALTH CARE PROVIDED THROUGH THE HEALTH PLAN.

C. THE QUALITY IMPROVEMENT PROGRAM SHALL INCLUDE AN ONGOING SYSTEM FOR MONITORING PATTERNS OF PRACTICE. THE COMMISSION SHALL APPOINT A HEALTH CARE PRACTICE ADVISORY COMMITTEE CONSISTING OF HEALTH CARE PRACTITIONERS, HEALTH

FACILITIES AND OTHER KNOWLEDGEABLE PERSONS TO ADVISE THE COMMISSION AND STAFF ON HEALTH CARE PRACTICE ISSUES. THE COMMITTEE MAY APPOINT SUBCOMMITTEES AND TASK FORCES TO ADDRESS PRACTICE ISSUES OF A SPECIFIC HEALTH CARE PRACTITIONER DISCIPLINE OR A SPECIFIC KIND OF HEALTH FACILITY IF THE SUBCOMMITTEE OR TASK FORCE INCLUDES PRACTITIONERS OF SUBSTANTIALLY SIMILAR SPECIALTIES OR TYPES OF FACILITIES. THE ADVISORY COMMITTEE SHALL PROVIDE TO THE COMMISSION RECOMMENDED STANDARDS AND GUIDELINES TO BE FOLLOWED IN MAKING DETERMINATIONS ON PRACTICE ISSUES.

D. WITH THE ADVICE OF THE HEALTH CARE PRACTICE ADVISORY COMMITTEE, THE COMMISSION SHALL ESTABLISH A SYSTEM OF PEER EDUCATION FOR HEALTH CARE PRACTITIONERS OR HEALTH FACILITIES DETERMINED TO BE ENGAGING IN ABERRANT PATTERNS OF PRACTICE PURSUANT TO SUBSECTION B. IF THE COMMISSION DETERMINES THAT PEER EDUCATION EFFORTS HAVE FAILED, THE COMMISSION MAY REFER THE MATTER TO THE APPROPRIATE LICENSING OR CERTIFYING BOARD.

E. THE COMMISSION SHALL PROVIDE BY RULE THE PROCEDURES FOR RECOUPING PAYMENTS OR WITHHOLDING PAYMENTS FOR HEALTH CARE DETERMINED BY THE COMMISSION WITH THE ADVICE OF THE HEALTH CARE PRACTICE ADVISORY COMMITTEE OR SUBCOMMITTEE TO BE MEDICALLY UNNECESSARY.

F. THE COMMISSION BY RULE MAY PROVIDE FOR THE ASSESSMENT OF ADMINISTRATIVE PENALTIES FOR UP TO THREE TIMES THE AMOUNT OF EXCESS PAYMENTS IF IT FINDS THAT EXCESSIVE BILLINGS WERE PART OF AN ABERRANT PATTERN OF PRACTICE. ADMINISTRATIVE PENALTIES SHALL BE DEPOSITED IN THE STATE GENERAL FUND.

G. AFTER CONSULTATION WITH THE HEALTH CARE PRACTICE ADVISORY COMMITTEE, THE COMMISSION MAY SUSPEND OR REVOKE A HEALTH CARE PRACTITIONER'S OR HEALTH FACILITY'S PRIVILEGE TO BE PAID FOR HEALTH CARE PROVIDED UNDER THE HEALTH PLAN BASED ON EVIDENCE CLEARLY SUPPORTING A DETERMINATION BY THE COMMISSION THAT THE PRACTITIONER OR FACILITY ENGAGES IN ABERRANT PATTERNS OF PRACTICE, INCLUDING INAPPROPRIATE UTILIZATION, ATTEMPTS TO UNBUNDLE HEALTH CARE SERVICES OR OTHER PRACTICES THAT THE COMMISSION DEEMS A VIOLATION OF THIS CHAPTER OR RULES ADOPTED PURSUANT TO THIS CHAPTER. FOR THE PURPOSES OF THIS SUBSECTION, "UNBUNDLE" MEANS TO DIVIDE A SERVICE INTO COMPONENTS IN AN ATTEMPT TO INCREASE OR WITH THE EFFECT OF INCREASING COMPENSATION FROM THE HEALTH PLAN.

H. THE COMMISSION SHALL REPORT A SUSPENSION OR REVOCATION OF THE PRIVILEGE TO BE PAID FOR HEALTH CARE PURSUANT TO THIS CHAPTER TO THE APPROPRIATE LICENSING OR CERTIFYING BOARD.

I. THE COMMISSION SHALL REPORT CASES OF SUSPECTED FRAUD BY A HEALTH CARE PRACTITIONER OR A HEALTH FACILITY TO THE ATTORNEY GENERAL OR TO THE COUNTY ATTORNEY OF THE COUNTY WHERE THE HEALTH CARE PRACTITIONER OR HEALTH FACILITY OPERATES FOR INVESTIGATION AND PROSECUTION.

36-3120. Judicial review

A PERSON WHO IS SPECIFICALLY AND DIRECTLY AGGRIEVED BY A FINAL DECISION OF THE COMMISSION MAY SEEK JUDICIAL REVIEW OF THE DECISION PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

36-3121. Health plan budget

A. THE COMMISSION SHALL DEVELOP AND SUBMIT TO THE LEGISLATURE AN ANNUAL HEALTH PLAN BUDGET. THE BUDGET SHALL BE THE COMMISSION'S RECOMMENDATION FOR THE TOTAL AMOUNT TO BE SPENT BY THE PLAN FOR COVERED HEALTH CARE SERVICES IN THE NEXT FISCAL YEAR.

B. UNLESS OTHERWISE PROVIDED BY LEGISLATIVE ACT, THE HEALTH PLAN BUDGET SHALL BE WITHIN PROJECTED ANNUAL REVENUES. AFTER THE LEGISLATIVE REVIEW AND APPROVAL, THE COMMISSION SHALL IMPLEMENT THE HEALTH PLAN BUDGET. WITHOUT SPECIFIC LEGISLATIVE APPROVAL, THE COMMISSION SHALL NOT CHANGE THE LEVEL OF PREMIUM CHARGED AND USED TO PROJECT REVENUE OR CHANGE THE EMPLOYER CONTRIBUTIONS UNDER THE HEALTH PLAN.

C. IN DEVELOPING THE HEALTH PLAN BUDGET, THE COMMISSION SHALL PROVIDE THAT CREDIT BE TAKEN IN THE BUDGET FOR ALL REVENUES PRODUCED FOR HEALTH CARE IN THIS STATE PURSUANT TO ANY LAW OTHER THAN THIS CHAPTER.

D. THE HEALTH PLAN SHALL INCLUDE A MAXIMUM AMOUNT OR PERCENTAGE FOR ADMINISTRATIVE COSTS, AND THIS MAXIMUM, IF A PERCENTAGE, MAY CHANGE IN RELATION TO THE TOTAL COSTS OF SERVICES PROVIDED UNDER THE HEALTH PLAN. FOR THE SIXTH AND SUBSEQUENT CALENDAR YEARS OF OPERATION OF THE HEALTH PLAN, ADMINISTRATIVE COSTS SHALL NOT EXCEED FIVE PER CENT OF THE HEALTH PLAN BUDGET.

36-3122. Payments to health care practitioners; copayments

A. THE COMMISSION SHALL PREPARE A PRACTITIONER BUDGET. CONSISTENT WITH THE PRACTITIONER BUDGET, THE HEALTH PLAN SHALL PROVIDE PAYMENT FOR ALL COVERED HEALTH CARE RENDERED BY HEALTH CARE PRACTITIONERS. A VARIETY OF PAYMENT PLANS, INCLUDING FEE-FOR-SERVICE, MAY BE ADOPTED BY THE COMMISSION. PAYMENT PLANS SHALL BE NEGOTIATED WITH PRACTITIONERS AS PROVIDED BY RULE. IF NEGOTIATION FAILS TO DEVELOP AN ACCEPTABLE PAYMENT PLAN, THE DISPUTING PARTIES SHALL SUBMIT THE DISPUTE FOR JUDICIAL REVIEW PURSUANT TO SECTION 36-3120.

B. SUPPLEMENTAL PAYMENT RATES MAY BE ADOPTED TO PROVIDE INCENTIVES TO HELP ENSURE THE DELIVERY OF NEEDED HEALTH CARE IN RURAL AND OTHER UNDERSERVED AREAS THROUGHOUT THE STATE.

C. AN ANNUAL PERCENTAGE INCREASE IN THE AMOUNT ALLOCATED FOR PRACTITIONER PAYMENTS IN THE BUDGET SHALL NOT BE GREATER THAN THE ANNUAL PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR MEDICAL CARE PRICES PUBLISHED BY THE BUREAU OF LABOR STATISTICS OF THE FEDERAL DEPARTMENT OF LABOR USING THE YEAR BEFORE THE YEAR IN WHICH THE HEALTH PLAN IS IMPLEMENTED AS THE BASELINE YEAR. THE ANNUAL LIMITATION IN THIS SUBSECTION MAY BE ADJUSTED UP OR DOWN BY THE COMMISSION BASED ON A SHOWING OF SPECIAL AND UNUSUAL CIRCUMSTANCES IN A HEARING BEFORE THE COMMISSION.

D. PAYMENT, OR THE OFFER OF PAYMENT WHETHER OR NOT THAT OFFER IS ACCEPTED, TO A HEALTH CARE PRACTITIONER FOR SERVICES COVERED BY THE HEALTH PLAN SHALL BE PAYMENT IN FULL FOR THOSE SERVICES. A HEALTH CARE PRACTITIONER SHALL NOT CHARGE A BENEFICIARY AN ADDITIONAL AMOUNT FOR SERVICES COVERED BY THE PLAN.

E. THE COMMISSION MAY ESTABLISH A COPAYMENT SCHEDULE IF A REQUIRED COPAYMENT IS DETERMINED TO BE AN EFFECTIVE COST-CONTROL MEASURE. A COPAYMENT SHALL NOT BE REQUIRED FOR PREVENTIVE HEALTH CARE. IF A COPAYMENT IS REQUIRED, THE HEALTH CARE PRACTITIONER SHALL NOT WAIVE IT AND IF IT REMAINS UNCOLLECTED, THE HEALTH CARE PRACTITIONER SHALL DEMONSTRATE A GOOD FAITH EFFORT TO HAVE COLLECTED THE COPAYMENT.

36-3123. Payments to health facilities; co-payments

A. A HEALTH FACILITY SHALL NEGOTIATE AN ANNUAL OPERATING BUDGET WITH THE COMMISSION. THE OPERATING BUDGET SHALL BE BASED ON A BASE OPERATING BUDGET OF PAST PERFORMANCE AND PROJECTED CHANGES UPWARD OR DOWNWARD IN COSTS AND SERVICES ANTICIPATED FOR THE NEXT YEAR. IF A NEGOTIATED ANNUAL OPERATING BUDGET IS NOT AGREED ON, A HEALTH FACILITY SHALL SUBMIT THE BUDGET FOR JUDICIAL REVIEW PURSUANT TO SECTION 36-3120. AN ANNUAL PERCENTAGE INCREASE IN THE AMOUNT ALLOCATED FOR A HEALTH FACILITY OPERATING BUDGET SHALL NOT BE GREATER THAN THE CHANGE IN THE ANNUAL CONSUMER PRICE INDEX FOR MEDICAL CARE PRICES, PUBLISHED ANNUALLY BY THE BUREAU OF LABOR STATISTICS OF THE FEDERAL DEPARTMENT OF LABOR. THE ANNUAL LIMITATION IN THIS SUBSECTION MAY BE ADJUSTED UP OR DOWN BY THE COMMISSION BASED ON A SHOWING OF SPECIAL AND UNUSUAL CIRCUMSTANCES IN A HEARING BEFORE THE COMMISSION.

B. SUPPLEMENTAL PAYMENT RATES MAY BE ADOPTED TO PROVIDE INCENTIVES TO HELP ENSURE THE DELIVERY OF NEEDED HEALTH CARE SERVICES IN RURAL AND OTHER UNDERSERVED AREAS AS PRESCRIBED IN SECTION 36-2352, SUBSECTION A, PARAGRAPH 2, THROUGHOUT THE STATE.

C. EACH HEALTH CARE PRACTITIONER EMPLOYED BY A HEALTH FACILITY SHALL BE PAID FROM THE FACILITY'S OPERATING BUDGET IN A MANNER DETERMINED BY THE HEALTH FACILITY.

D. THE COMMISSION MAY ESTABLISH A COPAYMENT SCHEDULE IF A REQUIRED COPAYMENT IS DETERMINED TO BE AN EFFECTIVE COST-CONTROL MEASURE. A COPAYMENT SHALL NOT BE REQUIRED FOR PREVENTIVE CARE. IF A COPAYMENT IS REQUIRED, THE HEALTH FACILITY SHALL NOT WAIVE IT AND IF IT REMAINS UNCOLLECTED, THE HEALTH FACILITY SHALL DEMONSTRATE A GOOD FAITH EFFORT TO HAVE COLLECTED THE COPAYMENT.

36-3124. Health resource certificate; commission rules; requirement for review

A. THE COMMISSION SHALL ADOPT RULES STATING WHEN A HEALTH FACILITY OR HEALTH CARE PRACTITIONER PARTICIPATING IN THE HEALTH PLAN MUST APPLY FOR A HEALTH RESOURCE CERTIFICATE, HOW THE APPLICATION WILL BE REVIEWED, HOW THE CERTIFICATE WILL BE GRANTED, HOW AN EXPEDITED REVIEW IS CONDUCTED AND OTHER MATTERS RELATING TO HEALTH RESOURCE PROJECTS.

B. EXCEPT AS PROVIDED IN SUBSECTION F, A HEALTH FACILITY OR HEALTH CARE PRACTITIONER PARTICIPATING IN THE HEALTH PLAN SHALL NOT MAKE OR OBLIGATE ITSELF TO MAKE A MAJOR CAPITAL EXPENDITURE WITHOUT FIRST OBTAINING A HEALTH RESOURCE CERTIFICATE.

C. A HEALTH FACILITY OR HEALTH CARE PRACTITIONER SHALL NOT ACQUIRE THROUGH RENTAL, LEASE OR COMPARABLE ARRANGEMENT OR THROUGH DONATION ALL OR A

PART OF A CAPITAL PROJECT THAT WOULD HAVE REQUIRED REVIEW IF THE ACQUISITION HAD BEEN BY PURCHASE UNLESS THE PROJECT IS GRANTED A HEALTH RESOURCE CERTIFICATE.

D. A HEALTH FACILITY OR HEALTH CARE PRACTITIONER SHALL NOT ENGAGE IN COMPONENT PURCHASING IN ORDER TO AVOID THE REQUIREMENTS OF THIS SECTION.

E. THE COMMISSION SHALL GRANT A HEALTH RESOURCE CERTIFICATE FOR A MAJOR CAPITAL EXPENDITURE OR A CAPITAL PROJECT UNDERTAKEN PURSUANT TO SUBSECTION C ONLY IF THE PROJECT IS DETERMINED TO BE NEEDED.

F. THIS SECTION DOES NOT APPLY TO:

1. THE PURCHASE, CONSTRUCTION OR RENOVATION OF OFFICE SPACE FOR HEALTH CARE PRACTITIONERS.

2. EXPENDITURES INCURRED SOLELY IN PREPARATION FOR A CAPITAL PROJECT, INCLUDING ARCHITECTURAL DESIGN, SURVEYS, PLANS, WORKING DRAWINGS AND SPECIFICATIONS AND OTHER RELATED ACTIVITIES, BUT THOSE EXPENDITURES SHALL BE INCLUDED IN THE COST OF A PROJECT FOR THE PURPOSE OF DETERMINING WHETHER A HEALTH RESOURCE CERTIFICATE IS REQUIRED.

3. ACQUISITION OF AN EXISTING HEALTH FACILITY, EQUIPMENT OR PRACTICE OF A HEALTH CARE PRACTITIONER THAT DOES NOT RESULT IN A NEW SERVICE BEING PROVIDED OR IN INCREASED BED CAPACITY.

4. MAJOR CAPITAL EXPENDITURES FOR NONCLINICAL SERVICES IF THE NONCLINICAL SERVICES ARE THE PRIMARY PURPOSE OF THE EXPENDITURE.

5. THE REPLACEMENT OF EQUIPMENT WITH EQUIPMENT THAT HAS THE SAME FUNCTION AND THAT DOES NOT RESULT IN THE OFFERING OF NEW SERVICES.

G. NOT LATER THAN JANUARY 1, 2008, THE COMMISSION SHALL REPORT TO THE APPROPRIATE COMMITTEES OF THE LEGISLATURE ON THE CAPITAL NEEDS OF HEALTH FACILITIES, INCLUDING FACILITIES OF STATE AND LOCAL GOVERNMENTS, WITH A FOCUS ON UNDERSERVED GEOGRAPHIC AREAS WITH SUBSTANTIALLY BELOW-AVERAGE HEALTH FACILITIES AND INVESTMENT PER CAPITA AS COMPARED TO THE STATE AVERAGE. THE REPORT SHALL ALSO DESCRIBE GEOGRAPHIC AREAS WHERE THE DISTANCE TO HEALTH FACILITIES IMPOSES A BARRIER TO CARE. THE REPORT SHALL INCLUDE A SECTION ON HEALTH CARE TRANSPORTATION NEEDS, INCLUDING CAPITAL, PERSONNEL AND TRAINING NEEDS. THE REPORT SHALL MAKE RECOMMENDATIONS FOR LEGISLATION TO AMEND THIS CHAPTER THAT THE COMMISSION DETERMINES NECESSARY AND APPROPRIATE.

36-3125. Actuarial review; audits

A. THE COMMISSION SHALL PROVIDE FOR AN ANNUAL INDEPENDENT ACTUARIAL REVIEW OF THE HEALTH PLAN AND ANY FUNDS OF THE COMMISSION OR THE PLAN.

B. THE COMMISSION SHALL PROVIDE BY RULE REQUIREMENTS FOR INDEPENDENT FINANCIAL AUDITS OF HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES.

C. THE COMMISSION, THROUGH ITS STAFF OR BY CONTRACT, SHALL PERFORM ANNOUNCED AND UNANNOUNCED AUDITS, INCLUDING FINANCIAL, OPERATIONAL, MANAGEMENT AND ELECTRONIC DATA PROCESSING AUDITS OF HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES. AUDIT FINDINGS SHALL BE REPORTED DIRECTLY TO THE COMMISSION. THE STATE AUDITOR MAY BE ASKED BY THE COMMISSION TO REVIEW PRELIMINARY FINDINGS OR TO CONSULT WITH AUDIT STAFF BEFORE THE FINDINGS ARE REPORTED TO THE COMMISSION.

D. ACTUARIAL REVIEWS, FINANCIAL AUDITS AND INTERNAL AUDITS ARE PUBLIC DOCUMENTS AFTER THEY HAVE BEEN RELEASED BY THE COMMISSION IF THE REPORTS PROTECT PRIVATE AND CONFIDENTIAL INFORMATION OF A PATIENT OR PRACTITIONER. COPIES OF REVIEWS, AUDITS AND OTHER REPORTS SHALL BE TRANSMITTED TO THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. THE COMMISSION SHALL MAKE THESE DOCUMENTS AVAILABLE ON THE INTERNET AND SHALL PROVIDE COPIES OF THESE DOCUMENTS TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS.

36-3126. Standard claim forms for insurance payment

THE COMMISSION SHALL ADOPT STANDARD CLAIM FORMS AND ELECTRONIC FORMATS THAT SHALL BE USED BY ALL HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES THAT SEEK PAYMENT THROUGH THE HEALTH PLAN OR FROM PRIVATE PERSONS, INCLUDING PRIVATE INSURANCE COMPANIES, FOR HEALTH CARE SERVICES RENDERED IN THIS STATE. EACH CLAIM FORM OR ELECTRONIC FORMAT MAY INDICATE WHETHER A PERSON IS ELIGIBLE FOR FEDERAL OR OTHER INSURANCE PROGRAMS FOR PAYMENT. TO THE EXTENT PRACTICABLE, THE COMMISSION SHALL REQUIRE THE USE OF EXISTING, NATIONALLY ACCEPTED STANDARDIZED FORMS, FORMATS AND SYSTEMS.

36-3127. Computerized system

THE COMMISSION SHALL REQUIRE THAT ALL PARTICIPATING HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES PARTICIPATE IN THE HEALTH PLAN'S COMPUTER NETWORK THAT PROVIDES FOR ELECTRONIC TRANSFER OF PAYMENTS TO HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES, TRANSMITTAL OF REPORTS, INCLUDING PATIENT DATA AND OTHER STATISTICAL REPORTS, BILLING DATA, WITH SPECIFICITY AS TO PROCEDURES OR SERVICES PROVIDED TO INDIVIDUAL PATIENTS, AND ANY OTHER INFORMATION REQUIRED OR REQUESTED BY THE COMMISSION. TO THE EXTENT PRACTICABLE, THE COMMISSION SHALL REQUIRE THE USE OF EXISTING, NATIONALLY ACCEPTED STANDARDIZED FORMS, FORMATS AND SYSTEMS.

36-3128. Reports required; confidential information

A. THE COMMISSION, THROUGH THE STATE HEALTH INFORMATION SYSTEM, SHALL REQUIRE REPORTS BY ALL HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES OF INFORMATION NEEDED TO ALLOW THE COMMISSION TO EVALUATE THE HEALTH PLAN, COST-CONTAINMENT MEASURES, UTILIZATION REVIEW, HEALTH FACILITY OPERATING BUDGETS, HEALTH CARE PRACTITIONER FEES AND ANY OTHER INFORMATION THE COMMISSION DEEMS NECESSARY TO CARRY OUT ITS DUTIES PURSUANT TO THIS CHAPTER.

B. THE COMMISSION SHALL ESTABLISH UNIFORM REPORTING REQUIREMENTS FOR HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES.

C. INFORMATION THAT IS CONFIDENTIAL PURSUANT TO OTHER PROVISIONS OF LAW IS CONFIDENTIAL PURSUANT TO THIS CHAPTER. WITHIN THE CONSTRAINTS OF CONFIDENTIALITY, REPORTS OF THE COMMISSION ARE PUBLIC DOCUMENTS.

36-3129. Consumer, practitioner and health facility assistance program

A. THE COMMISSION SHALL ESTABLISH A CONSUMER, HEALTH CARE PRACTITIONER AND HEALTH FACILITY ASSISTANCE PROGRAM TO TAKE COMPLAINTS AND TO PROVIDE TIMELY AND KNOWLEDGEABLE ASSISTANCE TO:

1. ELIGIBLE PERSONS AND APPLICANTS ABOUT THEIR RIGHTS AND RESPONSIBILITIES AND THE COVERAGE PROVIDED IN ACCORDANCE WITH THIS CHAPTER.

2. HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES ABOUT THE STATUS OF CLAIMS, PAYMENTS AND OTHER PERTINENT INFORMATION RELEVANT TO THE CLAIMS PAYMENT PROCESS.

B. THE COMMISSION SHALL ESTABLISH A TOLL FREE TELEPHONE NUMBER FOR THE CONSUMER, HEALTH CARE PRACTITIONER AND HEALTH FACILITY ASSISTANCE PROGRAM AND SHALL HAVE PERSONS AVAILABLE THROUGHOUT THIS STATE TO ASSIST BENEFICIARIES, APPLICANTS, HEALTH CARE PRACTITIONERS AND HEALTH FACILITIES IN PERSON.

36-3130. Reimbursement for out-of-state services; health plan's right to subrogation and payment from other insurance plans

A. A BENEFICIARY MAY OBTAIN HEALTH CARE SERVICES COVERED BY THE HEALTH PLAN OUT OF STATE IF THE SERVICES ARE PAID AT THE SAME RATE THAT WOULD APPLY IF THE SERVICES WERE RECEIVED IN THIS STATE. HIGHER CHARGES FOR THOSE SERVICES SHALL NOT BE PAID BY THE HEALTH PLAN UNLESS THE COMMISSION NEGOTIATES A RECIPROCITY OR OTHER AGREEMENT WITH THE OTHER STATE OR WITH THE OUT-OF-STATE HEALTH CARE PRACTITIONER OR HEALTH FACILITY.

B. THE HEALTH PLAN SHALL MAKE REASONABLE EFFORTS TO ASCERTAIN ANY LEGAL LIABILITY OF THIRD PARTIES WHO ARE OR MAY BE LIABLE TO PAY ALL OR PART OF THE HEALTH CARE SERVICES COSTS OF INJURY, DISEASE OR DISABILITY OF A BENEFICIARY.

C. IF THE HEALTH PLAN MAKES PAYMENTS ON BEHALF OF A BENEFICIARY, THE HEALTH PLAN IS SUBROGATED TO ANY RIGHT OF THE BENEFICIARY AGAINST A THIRD PARTY FOR RECOVERY OF AMOUNTS PAID BY THE HEALTH PLAN.

D. BY OPERATION OF LAW, AN ASSIGNMENT TO THE HEALTH PLAN OF THE RIGHTS OF A BENEFICIARY:

1. IS CONCLUSIVELY PRESUMED TO BE MADE OF:

(a) A PAYMENT FOR HEALTH CARE SERVICES FROM ANY PERSON, FIRM OR CORPORATION, INCLUDING AN INSURANCE CARRIER.

(b) A MONETARY RECOVERY FOR DAMAGES FOR BODILY INJURY, WHETHER BY JUDGMENT, CONTRACT FOR COMPROMISE OR SETTLEMENT.

2. IS EFFECTIVE TO THE EXTENT OF THE AMOUNT OF PAYMENTS BY THE HEALTH PLAN.

3. IS EFFECTIVE AS TO THE RIGHTS OF ANY OTHER BENEFICIARIES WHOSE RIGHTS CAN LEGALLY BE ASSIGNED BY THE BENEFICIARY.

36-3131. Private health insurance coverage limited

A. AFTER THE DATE THE HEALTH PLAN IS OPERATING, A PERSON SHALL NOT PROVIDE PRIVATE HEALTH INSURANCE TO A BENEFICIARY FOR HEALTH CARE THAT IS COVERED BY THE HEALTH PLAN EXCEPT FOR RETIREE HEALTH INSURANCE PLANS THAT DO NOT ENTER INTO CONTRACTS WITH THE HEALTH PLAN. A BENEFICIARY MAY PURCHASE SUPPLEMENTAL BENEFITS.

B. THIS SECTION DOES NOT AFFECT INSURANCE COVERAGE PURSUANT TO THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 UNLESS THE STATE OBTAINS A CONGRESSIONAL EXEMPTION OR A WAIVER FROM THE FEDERAL GOVERNMENT.

BUSINESSES THAT ARE COVERED BY THAT ACT MAY ELECT TO PARTICIPATE IN THE HEALTH PLAN.

36-3132. Health plan fund; federal health insurance program waivers; reimbursement to health plan from federal and other health insurance programs

A. THE HEALTH PLAN FUND IS ESTABLISHED CONSISTING OF MONIES RECEIVED PURSUANT TO THIS CHAPTER. THE COMMISSION SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

B. THE COMMISSION SHALL PROVIDE FOR THE COLLECTION OF PREMIUMS FROM ELIGIBLE BENEFICIARIES, EMPLOYERS, STATE AND FEDERAL AGENCIES AND OTHER ENTITIES THAT WHEN COMBINED WITH MONIES APPROPRIATED TO THE FUND ARE SUFFICIENT TO PROVIDE THE REQUIRED HEALTH CARE SERVICES AND TO PAY THE EXPENSES OF THE COMMISSION AND ITS ADMINISTRATIVE FUNCTIONS. ALL PREMIUMS AND OTHER MONEY APPROPRIATED TO THE FUND SHALL BE CREDITED TO THE FUND.

C. THE COMMISSION SHALL:

1. APPLY TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR ALL WAIVERS OF REQUIREMENTS UNDER HEALTH CARE PROGRAMS ESTABLISHED PURSUANT TO THE FEDERAL SOCIAL SECURITY ACT THAT ARE NECESSARY TO ENABLE THE STATE TO DEPOSIT FEDERAL PAYMENTS FOR SERVICES COVERED BY THE HEALTH PLAN INTO THE HEALTH PLAN FUND AND TO BE THE SUPPLEMENTAL PAYER OF BENEFITS FOR PERSONS RECEIVING MEDICARE BENEFITS.

2. EXCEPT FOR THOSE PROGRAMS DESIGNATED IN SECTION 36-3112, IDENTIFY OTHER FEDERAL PROGRAMS THAT PROVIDE FEDERAL MONIES FOR PAYMENT OF HEALTH CARE SERVICES TO INDIVIDUALS AND APPLY FOR ANY WAIVERS OR ENTER INTO ANY AGREEMENTS THAT ARE NECESSARY TO ENABLE THE STATE TO DEPOSIT FEDERAL PAYMENTS FOR HEALTH CARE SERVICES COVERED BY THE HEALTH PLAN INTO THE HEALTH PLAN FUND IF AGREEMENTS NEGOTIATED WITH THE FEDERAL INDIAN HEALTH SERVICE DO NOT IMPAIR TREATY OBLIGATIONS OF THE UNITED STATES GOVERNMENT AND OTHER AGREEMENTS NEGOTIATED DO NOT IMPAIR PORTABILITY OR OTHER ASPECTS OF THE HEALTH CARE COVERAGE.

3. SEEK AN AMENDMENT TO THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 TO EXEMPT THIS STATE FROM THE PROVISIONS OF THAT ACT THAT RELATE TO HEALTH CARE SERVICES OR HEALTH INSURANCE, OR THE COMMISSION SHALL APPLY TO THE APPROPRIATE FEDERAL AGENCY FOR WAIVERS OF ANY REQUIREMENTS OF THAT ACT IF CONGRESS PROVIDES FOR WAIVERS TO ENABLE THE COMMISSION TO EXTEND COVERAGE PURSUANT TO THIS CHAPTER TO AS MANY ELIGIBLE RESIDENTS OF THIS STATE AS POSSIBLE.

D. THE COMMISSION SHALL SEEK PAYMENT TO THE HEALTH PLAN FROM MEDICAID, MEDICARE OR ANY OTHER FEDERAL OR OTHER INSURANCE PROGRAM FOR ANY REIMBURSABLE PAYMENT PROVIDED UNDER THE PLAN.

E. THE COMMISSION SHALL SEEK TO MAXIMIZE FEDERAL CONTRIBUTIONS AND PAYMENTS FOR HEALTH CARE SERVICES PROVIDED IN THIS STATE AND SHALL ENSURE THAT THE CONTRIBUTIONS OF THE FEDERAL GOVERNMENT FOR HEALTH CARE SERVICES IN THIS STATE WILL NOT DECREASE IN RELATION TO OTHER STATES AS A RESULT OF ANY WAIVERS, EXEMPTIONS OR AGREEMENTS.

36-3133. Voluntary purchase of other insurance

THIS CHAPTER DOES NOT PROHIBIT THE VOLUNTARY PURCHASE OF INSURANCE COVERAGE FOR HEALTH CARE SERVICES NOT COVERED BY THE HEALTH PLAN OR FOR INDIVIDUALS NOT ELIGIBLE FOR COVERAGE UNDER THE HEALTH PLAN.

36-3134. Insurance rates; superintendent of insurance duties

A. THE DEPARTMENT OF INSURANCE SHALL IDENTIFY PREMIUM COSTS ASSOCIATED WITH HEALTH CARE COVERAGE IN WORKERS' COMPENSATION AND AUTOMOBILE MEDICAL COVERAGE. THE DEPARTMENT OF INSURANCE SHALL DEVELOP AN ESTIMATE OF EXPECTED REDUCTION IN THOSE COSTS BASED ON ASSUMPTIONS OF HEALTH CARE SERVICES COVERAGE IN THE HEALTH PLAN AND SHALL REPORT THE FINDINGS TO THE SENATE FINANCE COMMITTEE, OR ITS SUCCESSOR COMMITTEE, AND THE HOUSE WAYS AND MEANS COMMITTEE, OR ITS SUCCESSOR COMMITTEE, TO DETERMINE THE FINANCING OF THE HEALTH PLAN.

B. THE DEPARTMENT OF INSURANCE SHALL LOWER WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE PREMIUMS ON INSURANCE POLICIES WRITTEN IN THIS STATE THAT HAVE A MEDICAL PAYMENT COMPONENT ON THE DATE THE HEALTH PLAN IS IMPLEMENTED.

36-3135. Temporary provision; transition period arrangements; publicly funded health care service plans

A. A PERSON WHO, ON THE DATE BENEFITS ARE AVAILABLE PURSUANT TO THIS CHAPTER, RECEIVES HEALTH CARE BENEFITS UNDER PRIVATE CONTRACT OR COLLECTIVE BARGAINING AGREEMENT ENTERED INTO BEFORE JULY 1, 2008 SHALL CONTINUE TO RECEIVE THOSE BENEFITS UNTIL THE CONTRACT OR AGREEMENT EXPIRES OR UNLESS THE CONTRACT OR AGREEMENT IS RENEGOTIATED TO PROVIDE PARTICIPATION IN THE HEALTH PLAN.

B. A PERSON COVERED BY A HEALTH CARE PLAN THAT HAS ITS PREMIUMS PAID FOR IN ANY PART BY PUBLIC MONEY, INCLUDING MONEY FROM THIS STATE, A POLITICAL SUBDIVISION OF THIS STATE, A STATE EDUCATIONAL INSTITUTION, A PUBLIC SCHOOL OR ANY OTHER ENTITY THAT RECEIVES PUBLIC MONEY TO PAY HEALTH INSURANCE PREMIUMS, SHALL BE COVERED BY THE HEALTH PLAN ON THE EFFECTIVE DATE THAT BENEFITS ARE AVAILABLE UNDER THE HEALTH PLAN.

Sec. 2. Title 41, chapter 27, article 2, Arizona Revised Statutes, is amended by adding section 41-3016.01, to read:

41-3016.01. Health care commission; termination July 1, 2016

A. THE HEALTH CARE COMMISSION TERMINATES ON JULY 1, 2016.

B. TITLE 36, CHAPTER 31 IS REPEALED ON JANUARY 1, 2017.

Sec. 3. Initial terms of members of the health care commission

A. Notwithstanding section 36-3102, Arizona Revised Statutes, as added by this act, the initial terms of members of the health care commission are:

1. Three terms ending January, 2010.
2. Three terms ending January, 2011.
3. Three terms ending January, 2012.

B. The governor, speaker of the house of representatives and the president of the senate shall make all subsequent appointments as prescribed by statute.

Sec. 4. Purpose

Pursuant to section 41-2955, subsection E, Arizona Revised Statutes, the health care commission is established to provide a comprehensive, fair and cost-effective health care system for all Arizonans.

Sec. 5. Conforming legislation

The legislative council staff shall prepare proposed legislation conforming the Arizona Revised Statutes to the provisions of this act for consideration in the forty-eighth legislature, first regular session.